

HRB LABOR ROUTING INFORMATION SHEETDate: March 20, 2020Division / Facility: HRB/ASDEmail to: Jeremy Rodriguez-Ortegacc: Melton Young- bcc: \_\_\_\_\_Documentation for: FML ALD LWOPHRB Staffed: DR MY JRO DS FMEmployee Name: Jeremy Rodriguez-OrtegaRodriguez-Ortega, Jeremy FMLA #2 Approved Intermittent, Self 03.20.2020Approved

Disapproved

FML Request # 2 Continuous Intermittent~~ALD Request # \_\_\_\_\_~~

LWOP Request # \_\_\_\_\_

Dates: March 3, 2020 through July 8, 2020Additional Information: Approved Intermittent care of self.Freq: <sup>up to</sup> 1-2 times per week Duration: Up to 2 days per episode.Appointments, Therapies, treatments as needed. ALL prescheduled appointments must be provided to mgr/supr at least 3 days in advance.Contact Dave RE with Questions

New Year of FMLA

# NEW MEXICO DEPARTMENT OF HEALTH

## FAMILY AND MEDICAL LEAVE REQUEST

FMLA#2 is an amendment to Jeremy's FMLA#1 approved for 7/9/2019 - 7/8/2020, due to increased medical need for frequency and duration of coverage. It was approved through end of current FMLA year (July 8, 2020).

## GENERAL PROVISIONS:

- Employee must request Family and Medical Leave (FMLA) thirty (30) days in advance or as soon as practicable under the facts and circumstances of the particular case.
- Employees who have been in either classified or exempt service for at least 12 months and who have worked for at least 1250 hours during the last 12 months are entitled to leave under FMLA.
- FMLA may be requested for the care of the employee's child (birth, or placement for adoption or foster care); for the care of the employee's spouse, son or daughter, or parent, who has a serious health condition; or, for a serious health condition that makes the employee unable to perform their job.
- A serious health condition includes conditions or illnesses affecting one's health to the extent that inpatient care is required as well as absences necessary on a recurring basis or for more than a few days for treatment or recovery. In the absence of inpatient care, a serious health condition will require more than 3 days of illness and continuing treatment by a health care provider.
- A Certification of Health Care Provider from or other documentation as appropriate will be required when making request.

EMPLOYEE NAME:

Jeremy Rodriguez-Ortega  
NMDOH/ASD/HRB

EMPLOYEE ID#

110055

Division or Facility where employed:

Hire Date

1-26-1998

at the state of NM.

Is your spouse employed by a State Agency or the Department of Health?

Yes

No

If "YES", please complete items (a) through (c):

- Name of Spouse: \_\_\_\_\_ Employee ID# \_\_\_\_\_
- Agency, Division or Facility where employed: \_\_\_\_\_
- Will your spouse also request or has your spouse requested FMLA leave for the same reason/health condition for which you are requesting FMLA leave? Yes \_\_\_\_\_ No ☒

## REASON FOR REQUESTING FMLA LEAVE:

Place a check in the appropriate space below and ATTACH APPROPRIATE DOCUMENTATION TO SUPPORT REQUEST:

- N/A To care for my child after birth or N/A placement for adoption, or N/A foster care.  
N/A To care for my spouse N/A To care for my domestic partner. N/A To care for son or daughter.  
N/A To care for a parent. N/A To care for a person in loco parentis. ☒ Personal illness

## LEAVE REQUESTED: (THIS MUST BE COMPLETED BY THE EMPLOYEE)

- Indicate type of leave requested:  
☒ Annual Leave ☒ Sick Leave  
☒ Unpaid Leave ☒ Personal Leave  
☒ Compensatory Leave
- Will leave be continuous, ☒ intermittent, or reduced work schedule
- Leave dates: From March 31, 2020 through July 8, 2020.

EMPLOYEE SIGNATURE:

Jeremy Rodriguez-Ortega

DATE: 3-5-2020

12 MONTH FML START DATE:

7-9-2019 through 7-8-2020 FML HOURS USED: \_\_\_\_\_

Does employee qualify for FMLA Leave?

YES

YES

NO

HR ACKNOWLEDGEMENT OF REQUEST:

[Signature]

DATE:

March 4, 2020

(FOR HRB USE ONLY)

LABOR RELATIONS MANAGER APPROVAL:

[Signature]

DATE:

March 18, 2020

\*ALL SECTIONS OF THIS FORM MUST BE COMPLETED\*

Revised 11/14/14  
FMLA Request

# Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor  
Wage and Hour Division



OMB Control Number: 1235-0003

Expires: 8/31/2021

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: March 20, 2020Date: Arummy Rodriguez-Ortega

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided.  
We received your most recent information on 3/16/2020 and decided:

☒ Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

N/A Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: \_\_\_\_\_

☒ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

☒ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement, or unpaid FMLA

☐ We are requiring you to substitute or use paid leave during your FMLA leave.

☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position is is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

☐ Additional information is needed to determine if your FMLA leave request can be approved:

☐ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than \_\_\_\_\_, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.  
(Provide at least seven calendar days)

(Specify information needed to make the certification complete and sufficient)

☐ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

☐ Your FMLA Leave request is Not Approved.

☐ The FMLA does not apply to your leave request.

☐ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

## PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617, 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.

Form WH-382 January 2009

NMDOH Rodriguez-Ortega No. 0353



**Certification of Health Care Provider for  
Employee's Serious Health Condition  
(Family and Medical Leave Act)**

U.S. Department of Labor  
Wage and Hour Division



DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT

OMB Control Number: 1235-0003  
Expires: 4/31/2021

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: The New Mexico Department of Health / SONM

Employee's job title: HR. Labor and Training Sec. A

Regular work schedule: 7:30 to 4:30 1 hour lunch

Employee's essential job functions: all HR functions related to labor.

Check if job description is attached: N/A

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: Jeremy Ernest Rodriguez-Ortega  
First Middle Last

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: C. Gentiana Volnescu, MD  
2904 Rodeo Park Dr. E. Suite 300B  
Santa Fe, N.M. 87505

Type of practice / Medical specialty: Nephrology

Telephone: (505) 246-3466

Fax: ( )

**PART A: MEDICAL FACTS**1. Approximate date condition commenced: ① chronic pancreatitis with acute exacerbationProbable duration of condition: January 2017

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ No ☒ Yes. If so, dates of admission:Last admission Feb 20 - Feb 23, 2020.

Date(s) you treated the patient for condition:

March 2007Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☒ Yes.Was medication, other than over-the-counter medication, prescribed? ☐ No ☒ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

☐ No ☒ Yes. If so, state the nature of such treatments and expected duration of treatment:GI2. Is the medical condition pregnancy? ☒ No ☐ Yes. If so, expected delivery date: \_\_\_\_\_

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ☒ No ☒ Yes.

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Episodes of acute pancreatitis/gastritis — with potential need for hospitalization.

**PART B: AMOUNT OF LEAVE NEEDED**

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☒ No ☐ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ No ☒ Yes. *primarily*

If so, are the treatments or the reduced number of hours of work medically necessary?  
☐ No ☒ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

*aprox 1 x/week*

Estimate the part-time or reduced work schedule the employee needs, if any:

\_\_\_\_\_ hour(s) per day; 4 days per week from 3/5/2020 through June 2020

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ No ☒ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?  
☐ No ☒ Yes. If so, explain:

*during flareups he requires IV infusions.*

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : 1-2 times per \_\_\_\_\_ week(s) ☒ month(s)

Duration: \_\_\_\_\_ hours or 3 day(s) per episode

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER**

Signature of Health Care Provider

Date

3/5/20

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

# Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor  
Wage and Hour Division



OMB Control Number: 1235-0003  
Expires 8/31/2021

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

## [Part A - NOTICE OF ELIGIBILITY]

TO: Jaimey Rodriguez-Ortega  
Employee

FROM: David Rich, Labor Mgr.  
Employer Representative

DATE: March 4, 2020

On March 4, 2020 you informed us that you needed leave beginning on July 9, 2019 for:

- ☒ The birth of a child, or placement of a child with you for adoption or foster care;
- ☒ Your own serious health condition;
- ☐ Because you are needed to care for your ☐ spouse; ☐ child; ☐ parent due to his/her serious health condition.
- ☐ Because of a qualifying exigency arising out of the fact that your ☐ spouse; ☐ son or daughter; ☐ parent is on covered active duty or call to covered active duty status with the Armed Forces.
- ☐ Because you are the ☐ spouse; ☐ son or daughter; ☐ parent; ☐ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

☒ US Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

☐ Are not eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

- ☐ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ☐ months towards this requirement.
- ☐ You have not met the FMLA's hours of service requirement.
- ☐ You do not work and/or report to a site with 50 or more employees within 75 miles.

If you have any questions, contact Melton Young, FMLA Coordinator or view the FMLA poster located in (2) (505) 827-2543.

## [PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by March 19, 2020. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

- ☒ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ☒ is/ ☐ is not enclosed.
- ☐ Sufficient documentation to establish the required relationship between you and your family member.
- ☐ Other information needed (such as documentation for military family leave) \_\_\_\_\_

No additional information requested



If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA leave (only checked blanks apply):

- ☐ Contact \_\_\_\_\_ at \_\_\_\_\_ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.
- ☒ You will be required to use your available paid ☒ sick, ☒ vacation, and/or ☒ other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.
- ☐ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ☐ have/ ☐ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.
- ☐ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every \_\_\_\_\_. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following rights while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
  - ☐ the calendar year (January – December)
  - ☐ a fixed leave year based on \_\_\_\_\_
  - ☒ the 12-month period measured forward from the date of your first FMLA leave usage.
  - ☐ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on \_\_\_\_\_.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have ☐ sick, ☐ vacation, and/or ☐ other leave run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

☒ For a copy of conditions applicable to sick/vacation/other leave usage please refer to Agencies another Leave Policy available on the ChileNet.

Applicable conditions for use of paid leave:

FMLA, Annual leave requested in advance  
and sick leave.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

DAVID RICH at (505) 827.2984

#### PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities 29 U.S.C. § 2617, 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616, 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.

(Provider should read.)

### **GINA Notice to Avoid Providing Genetic Information**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic diseases for which an individual may be at risk.

Geremy Rodriguez-Ortega 3/5/2020

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3/4/2020

DR Jennifer M. Rodriguez-Ortega  
 is eligible for a new FMLA year  
 starting retro-actively back to the  
 beginning of his new FMLA year  
 (July 9, 2019 through July 8, 2020).

Measured regular hours worked  
 from 7/9/2018 through 7/8/2019  
 (the year preceding start date  
 of new FML year.

David Q  
 HRB Labor  
 3/4/2020